PROVIDER/SERVICE COORDINATOR DOCUMENTATION GUIDELINES

Effective documentation is critical in the early intervention process. It serves as a blueprint for service provision as well as a means for accountability. Because the IFSP must be reviewed every 6 months, effective documentation will assist the service coordinator in completing this review successfully. Since service coordinators and parents will use this documentation, it must provide all relevant facts in an organized manner (Dunn, 1991).

In the role of communication, documentation must be efficient and effective. To do this best, one must consider the intended audience (Dunn, 2000; McGuire, 1997). Because the primary audience in First Steps is the family, it is important to use person-first language, avoid jargon, be respectful, and relate comments back to performance concerns.

A progress note is defined as a document used periodically to specify care coordination, interventions, and progress toward functional outcomes, update outcomes, and review the individual clinical plan in general. The American Occupational Therapy Association (AOTA) outlines the following as content:

1. Activities, techniques, and modalities used
2. Consumer's progress
3. Goal continuance
4. Goal modification when indicated by the response to therapy or by the establishment of new consumer needs
5. Change in anticipated time to achieve goals
6. Consumer-related conferences and communication
7. Home programs
8. Plan

It is important that a progress note focus on function, underlying causes, state expectations for progress, and explain slow progress/lack of progress (McGuire, 1997). Short-term objectives are more sensitive to relatively small gains toward the long-term goal. It is also valuable for detecting in a timely manner when a program needs modifying. It is up to a therapist, team, and family to determine a hypothesis for what is serving as a barrier for functioning, and how this information this will drive the short-term objectives (Dunn, 1991).

A simple guideline for ensuring good documentation is known as RUMBA, where R=Relevant, U=Understandable, M=Measurable, B=Behavioral, and A=Achievable. Documentation can be a daunting and challenging task. Providing the right support through a solid documentation format will facilitate best practices and support service providers in accomplishing best practices, and this will promote quality care for infants and toddlers. Ultimately, this is the intent of IDEA '97, Part C.

Medicaid requirements for documentation:

Recipient's complete name
Date service was provided
Actual treatment provided on the date of service (detailed)
Actual time service was delivered
Copy of IFSP/Physician IFSP Summary requiring services

Purpose of documentation:

1. Provide a chronological record of the consumer's condition, which details the complete course of therapeutic intervention.
2. Facilitate communication among professionals and with family.
3. Provide an objective basis to determine the appropriateness, effectiveness, and necessity of therapeutic intervention.
4. Reflect practitioner's reasoning.

Provider Progress Reports:

The Service Provider Daily Progress Report represents the provider's contact summary that documents the individual service contacts. This is retained in the provider's clinical record for each child and is not sent to the Service Coordinator. First Steps has created a form that providers can use for this purpose, or the provider may choose to use a different format that captures the same information. Therefore, **this form is optional.**

All providers should maintain daily progress reports for all children served in the First Steps system. This documentation is required for audit purposes by the various funding sources utilized by the First Steps system. If no contact was scheduled for the period, there is no need to submit a progress report. If contact was scheduled and did not occur, a progress report should be completed.

The Service Provider Monthly Progress Report is completed by the provider and sent to the Service Coordinator on a monthly basis, the specific due date to be mutually determined at the IFSP team meeting. This one-page form summarizes the progress made on individual IFSP Outcome(s) that the provider is working on with the family and others. The individual provider reviews the progress report with the family and obtains their signature to document that the review has occurred. If the progress is communicated to the family by telephone or other means, the provider will document this when completing the progress report in lieu of parent signature.

The family and the family's Service Coordinator will be provided a copy of each monthly progress report by the provider. The Service Coordinator is responsible to review these progress reports and to work with the family and individual provider(s) should problems arise, or if the IFSP needs an interperiodic review. The monthly progress report is forwarded to the SPOE by the Service Coordinator

for inclusion in the child's EI record. Service Coordinators should ask about progress on "other" services, but they are not required to track or collect formal progress reports about these "other" services

A template for the Monthly Progress Report is provided by First Steps and must be used by all providers.

The Service Coordinator Case Note represents a summary of each contact (phone calls, meetings, letters, etc.) the service coordinator has with the family, provider, SPOE, etc. that directly relates to the child.

Importance of Case Notes for IFSP Team meetings:

These case notes provide the opportunity to capture discussion and relevant items **that are not** contained or reflected in the IFSP, but may be important for future consideration or documentation. The case notes are the appropriate place to document such items as:

- areas of disagreement, or recommendations that were not reflected in the final IFSP
- parent participation and lack of agreement to services that were recommended but not consented to by the parent/legal guardian

Case notes are maintained in the SC clinical file (copy) and originals are forwarded to the SPOE on a quarterly basis. The quarter begins the month of the Initial IFSP. A case note is the service coordinators documentation of contact for routine monitoring and audit purposes.

A case note format is provided by First Steps and is a required form. (Note: The DMH's current logging system is used in place of this template).